STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175295	A. BUILDING _____ B. WING _____	R 01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERET HEALTH AND REHAB AT SMITH CENTER LLC	117 W 1ST ST #369 SMITH CENTER, KS 66967

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of the Health Resurvey.	F 000		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: The facility had a census of 26 residents. The sample included 10 residents. Based on observation and interview the facility failed to provide a homelike dining environment for the 25 residents who eat their meals in the facility's dining room on 3 of the 4 onsite days. Findings included: - On 1/6/14 at 12:10 PM, observation in the dining room revealed the staff served the noon meal to the residents. Further observation revealed the plates/dishes of food were served on trays and then staff placed the entire tray in front of each resident. On 1/7/14 at 7:50AM, observation revealed the staff served the residents' breakfast meal in dishes, on trays, which staff then placed in front of each resident. On 1/8/14 at 12:00 PM, observation revealed the staff served the residents' noon meal in dishes,	F 252		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175295	A. BUILDING _____ B. WING _____	R 01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 252	Continued From page 1 on trays, and placed the entire tray in front of each resident. On 1/8/14 at 12:15 PM, Dietary Staff B verified the residents' meals were served on trays and the dinner ware remained on the tray. Dietary Staff B stated it made it easier to clean the tables with the dinner ware left on the trays. On 1/8/14 at 4:40 PM, Administrative Staff A verified the staff should not leave the plates and dinner ware on the trays. The dinner ware should be taken off the resident's trays and placed on the dining tables. The facility failed to provide a homelike dining environment for the 25 residents who reside in the facility and eat their meals in the dining room.	F 252		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility had a census of 26 residents. The sample included 10 residents. Based on observation and interview, the facility failed to provide and maintain a sanitary, orderly and comfortable interior for the 26 residents who reside on 3 of 3 halls in the facility. Findings included: - On 1/8/14 at 3:00 PM, during the environmental	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175295	A. BUILDING _____ B. WING _____	R 01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERET HEALTH AND REHAB AT SMITH CENTER LLC	117 W 1ST ST #369 SMITH CENTER, KS 66967

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F 253	Continued From page 2	F 253		

tour, observation revealed the following:

North Hallway:
1) Resident #10's bedroom door kick panel had an approximate 5 inch split and buckle on the side.
2) Resident #19's bathroom toilet had a brown substance on the caulking around the base of the toilet.
3) North Hallway Whirlpool bathroom door kick panel on the front with jagged edges, back of the door with an approximate 5 inch strip of wood missing and an approximate 1 inch L shaped gash in the lower part of the door, linoleum with numerous 1 inch slits in front of the whirlpool tub, caulking along backsplash of sink with a brown substance on it, linoleum loose and pulling up from the floor under the toilet paper holder, locked cabinet with chemicals inside - all shelves with brownish gray substance, mirror frame with chipped paint on edges, step stool with rust around edges of top and base board with an approximate 3 inch piece missing and brown substance at base.

West Hallway
1) Resident #21 and #7 shared a bathroom and towel bars not marked to identify which bar belonged to which resident.
2) Resident #7's bathroom door kick panel with jagged edges on both sides of the lower door.
3) Resident #9's bedroom door kick panel with a 1 inch x 2 inch chip on the lower left side.
4) Resident #28's bedroom door with jagged edges on lower part of kick panel. 5) Resident #25's bedroom door kick panel with jagged edges on the lower part. 6) Resident #1's bedroom door kick panel with jagged edges.
7) West Hallway bathroom door kick panel with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175295	A. BUILDING _____ B. WING _____	R 01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 253	Continued From page 3	F 253		

jagged edges, caulking around the base of the toilet with brown substance, linoleum with chips at entry to the shower, and toilet bowl with yellowish/brown stains.
8) Resident #26's toilet bowl with yellowish/brown stains.
9) Resident #14's caulking around the base of toilet with brownish substance.
10) Resident #5's bedroom door kick panel with jagged and split edges.

South Hallway:
1) Resident #20's bedroom door kick panel with chipped and jagged edges on the lower right side, sour odor in room, front of bathroom door kick panel with approximate 3 inch x 3 inch strip missing, back of bathroom door kick panel pulling away from door with jagged edges, and wall by door to the bathroom with deep gouge approximately 2 feet up from floor approximately 3 feet long.
2) Resident #36 entrance to bedroom missing threshold between carpet and linoleum.
3) Resident #15 entrance to bedroom missing threshold between carpet and linoleum and bedroom door with approximate 2 inch x 6 inch chunk missing.
4) Resident #4's bedroom door kick panel chipped on both sides with jagged edges.
5) Resident #35's bedroom door kick panel with jagged edges approximately 6 inches on left side.
6) Resident #11's bedroom door with approximately 6 inches of splintered edge.
7) Resident #24's bedroom door kick panel with jagged edges on right side.
8) Resident #6's bedroom door kick panel with approximate 2 inch x 4 inch piece of lower right side missing.
9) Resident #17's bedroom door kick panel with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175295	A. BUILDING _____ B. WING _____	R 01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERET HEALTH AND REHAB AT SMITH CENTER LLC	117 W 1ST ST #369 SMITH CENTER, KS 66967

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 4 approximate 1 inch x 2 inch chip missing on lower front, toilet caulking with brown substance around base, and stool riser handles loose. During the environmental tour, on 1/8/14 at 3:00 PM, Maintenance Supervisory Staff I and J verified the observations of the above findings. The facility failed to maintain a sanitary, orderly and comfortable environment for the 26 residents who reside on 3 of 3 halls in the facility.	F 253		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility had a census of 26 residents. The sample included 10 residents. The facility failed to maintain the highest practicable physical well being for 1 of 10 sampled residents for improper positioning on 3 of 4 days (#21) Findings included: - Resident #21's annual (MDS) Minimum Data Set 3.0 assessment, dated 12/10/13, indicated the resident had severely impaired cognition, total dependence on 2 staff for bed mobility, transfer, dressing, toilet use, and a range of motion	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175295	A. BUILDING _____ B. WING _____	R 01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERET HEALTH AND REHAB AT SMITH CENTER LLC	117 W 1ST ST #369 SMITH CENTER, KS 66967

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 5	F 309		

impairment with his/her lower extremities on both sides of his/her body. The MDS indicated the resident used a wheelchair and received antipsychotic, antidepressant and diuretic medications.

The 12/20/13 care plan directed the staff to position the resident for comfort with physical support as necessary, use a wheelchair for long distances and a gel cushion for pressure reduction when in his/her wheelchair.

The 9/24/13 occupational therapy evaluation stated the resident had decreased sitting endurance when unsupported, unable to bend his/her knees to place on the foot pedals, and would benefit from occupational therapy to improve sitting/standing endurance.

The 10/1/13 physical therapy daily progress note stated the resident participated in an activity while seated in a wheelchair with the foot rests attached and a pillow placed under the resident's feet.

The 11/5/13 physician's order sheet included a diagnosis for Resident #21 of venous insufficiency - a condition in which the veins have problems sending blood from the legs back to the heart.

On 1/7/14 at 11:19 AM, observation revealed the resident seated in a wheelchair with an approximate 3 inch cushion in the wheelchair, and no foot pedals on wheelchair. Observation revealed the resident's legs hanging over the edge of the cushion, dangling approximately 5-6 inches above the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175295	A. BUILDING _____ B. WING _____	R 01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERET HEALTH AND REHAB AT SMITH CENTER LLC	117 W 1ST ST #369 SMITH CENTER, KS 66967

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 6	F 309		

On 1/7/14 at 12:55 PM, observation revealed the resident seated in his/her room in a wheelchair with an approximate 3 inch cushion in the wheelchair and no foot pedals on wheelchair. Observation revealed the resident's legs hanging over the edge of the cushion, dangling approximately 5-6 inches above the floor.

On 1/7/14 at 1:15 PM, observation revealed the resident seated in his/her room, in a wheelchair, with an approximate 3 inch cushion in the wheelchair and no foot pedals on wheelchair. Observation revealed the resident's legs hanging over the edge of the cushion, dangling approximately 5 inches from the floor and the resident with a facial grimace. Further observation revealed the foot pedals to the wheelchair in the closet.

On 1/7/14 at 1:51 PM, observation revealed the resident lying in bed on his/her back with his/her eyes closed and face relaxed.

On 1/8/14 at 7:52 AM, observation revealed the resident seated in a wheelchair, pushed by the staff into the dining room no foot pedals on the wheelchair, and a cushion under the resident approximately 3 inch thick. Observation revealed the resident's legs hanging over the edge of the cushion, dangling approximately 5 inches above the floor.

On 1/8/14 at 11:21 AM, observation revealed the resident seated in a wheelchair, in the living room area with other residents with a cushion under the resident approximately 3 inch and no foot pedals on the wheelchair. Observation revealed the resident's legs hanging over the edge of the cushion, dangling approximately 5 inches above

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175295	A. BUILDING _____ B. WING _____	R 01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERET HEALTH AND REHAB AT SMITH CENTER LLC	117 W 1ST ST #369 SMITH CENTER, KS 66967

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 7	F 309		

the floor.

On 1/9/14 at 8:01 AM, observation revealed the resident seated in a wheelchair at the dining room table awaiting breakfast with the approximately 3 inch cushion in the wheelchair with no foot pedals on the wheelchair. Observation revealed the resident's legs hanging over the edge of the cushion, dangling approximately 3-5 inches above the floor.

On 1/9/14 at 8:47 AM, observation revealed the staff pushed the resident into his/her room in a wheelchair with an approximate 3 inch cushion in the wheelchair and no foot pedals on the wheelchair. Observation revealed the resident's legs hanging over the edge of the cushion approximately 4 inches above the floor. Observation revealed the staff positioned the resident in front of the television, clipped the call light to the resident and left the resident's room.

On 1/9/14 at 8:47 AM, Direct Care Staff E stated the resident used to have foot pedals on his/her wheelchair but his/her feet didn't touch the foot pedals. Direct Care Staff E indicated Occupational Therapy provided the wheelchair for the resident and he/she did not receive instructions to use the foot pedals for the resident.

On 1/9/14 at 11:25 AM, Direct Care Staff F stated the resident's feet have never touched the foot pedals on the wheelchair so the staff don't use them. Direct Care Staff F stated he/she had not told the occupational therapy staff the resident's feet did not touch the foot pedals.

On 1/9/14 at 10:18 AM, Licensed Nurse D stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175295	A. BUILDING _____ B. WING _____	R 01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERET HEALTH AND REHAB AT SMITH CENTER LLC	117 W 1ST ST #369 SMITH CENTER, KS 66967

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8 the staff should place the foot pedals on the resident's wheelchair and he/she was not aware the staff were not putting the foot pedals on the wheelchair. Licensed nursing staff D stated the therapy staff had completed a positioning evaluation on the resident and the resident should not have his/her legs hanging over the edge of the cushion in the wheelchair for long periods of time due to his/her poor circulation. On 1/9/14 at 12:21 PM, Occupational Therapy staff G stated the resident worked with therapy approximately 2 times a week for 4-6 weeks and he/she had foot pedals on the wheelchair each time. Therapy staff G stated he/she is not sure why the direct care staff stopped using the foot pedals and the resident should not have his/her legs dependently hanging for any period of time due to his/her poor circulation. The facility failed to provide Resident #21 with adequate positioning for 3 of 4 days of the survey.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 26 residents. The sample included 10 residents. Based on	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175295	A. BUILDING _____ B. WING _____	R 01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERET HEALTH AND REHAB AT SMITH CENTER LLC	117 W 1ST ST #369 SMITH CENTER, KS 66967

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9	F 323		

observation, record review and interview the facility failed to provide an environment that was free from accident hazards for the residents who reside in the facility of which 4 were cognitively impaired and independently mobile.

Findings included:

- On 1/6/14 at 9:49 AM, observation during the initial tour revealed the unlocked housekeeping closet and cart contained the following:

1) Betco Hard As Nails floor finish, the full 1 gallon container and half full 1 gallon container with warning labels that directed the staff to "Keep Out Of Reach of Children" and "Eye irritant, vapor and spray harmful".
2) Betco Hybrid floor finish, the half full 1 gallon container with warning label that directed the staff to "Keep Out Of Reach of Children" and "May cause eye irritation".
3) Zep Neutral floor cleaner, 2 - 1 gallon containers each half full with warning labels that directed the staff to "Keep Out Of Reach of Children" and "Irritant".
4) Zep Stain Resistant Floor sealer, 1 gallon container half full with a warning label that directed the staff to "Keep Out Of Reach of Children" and "Irritant".
5) Comet cleanser, a 21 (oz) ounce can 1/4 full with warning label that directed the staff "May cause skin and eye irritation" and "Keep Out Of Reach of Children".
6) Raid Wasp and Hornet Spray, one 14 oz can half full with a warning label that directed the staff to "Avoid contact with skin, If swallowed - call physician, and Keep Out Of Reach of Children".
7) Butcher's Iron Stone Acrylic seal, 1 gallon half full with warning label that directed the staff if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175295	A. BUILDING _____ B. WING _____	R 01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERET HEALTH AND REHAB AT SMITH CENTER LLC	117 W 1ST ST #369 SMITH CENTER, KS 66967

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10	F 323		

"medical emergency - call the number listed".
8) Semi Gloss paint, a full gallon and 1 - half full gallon with warning labels that directed the staff to "Keep Out Of Reach of Children" and "Flammable".
9) Scotch Guard water repellant, a 12 oz can half full with warning label that directed the staff to "Keep Out Of Reach of Children" and "Extremely Flammable".

The unlocked house cleaning cart contained the following:
1) Betco Toilet Cleaner Kling, a 32 oz spray bottle 1/4 full with warning label that directed the staff to "Keep Out Of Reach of Children" and "Irritant".
2) Betco Disinfectant, a 32 oz spray bottle half full with a warning label that directed the staff to "Keep Out Of Reach of Children" and "Irritant".
3) WD-40, a 16 oz spray can half full with a warning label that directed the staff to "Keep Out Of Reach of Children, Irritant, and Flammable".
4) Huntingdon Supply Company Dust Mop Treatment, a 32 oz spray bottle half full with a warning label which stated "Prolonged or repeated contact with skin or eyes may cause irritation or reddening and vapor harmful".

On 1/7/14 at 8:00 AM, during call light testing, the unlocked chemical cabinet in the whirlpool bathroom contained the following:

1) Betco disinfectant, a 14 oz can half full with a warning label which stated "Keep Out Of Reach of Children and Eye Irritant".

On 1/8/14 at 8:45 AM, during observation of a room being cleaned, the unlocked housekeeping cart door with a broken lock contained the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175295	A. BUILDING _____ B. WING _____	R 01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERET HEALTH AND REHAB AT SMITH CENTER LLC	117 W 1ST ST #369 SMITH CENTER, KS 66967

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11	F 323		

1) TWL Propell Spray and Walk Away Stain Treatment, the 32 oz spray bottle 1/4 full with a warning label that directed the staff to "Keep Out Of Reach of Children and Causes eye and skin irritation".
2) TWL Propel Odor Eliminator, the 32 oz spray bottle 1/4 full with a warning label that directed the staff to "Keep Out Of Reach of Children".
3) Air Wick Air Freshener, an 8 oz spray can 1/4 full with a warning label that directed the staff to "Keep Out Of Reach of Children and Eye Irritant".
4) Ecolab Bathroom Disinfectant Cleaner 2.0, 1 full and 1 - half full 32 oz spray bottle, with a warning label on the dispenser that directed the staff "Acute toxicity skin, serious eye damage/eye irritation".

- On 1/8/14 at 3:00 PM, during the environmental tour, observation revealed the following:

North Hallway:
1) Resident #10's bedroom door kick panel had an approximate 5 inch split and buckle on the side.
2) North Hallway Whirlpool bathroom door kick panel on the front with jagged edges, back of the door with an approximate 5 inch strip of wood missing and an approximate 1 inch L shaped gash in the lower part of the door, and linoleum loose and pulling up from the floor under the toilet paper holder.

West Hallway
1) Resident #7's bathroom door kick panel with jagged edges on both sides of the lower door.
2) Resident #9's bedroom door kick panel with a 1 inch x 2 inch chip on the lower left side.
3) Resident #28's bedroom door with jagged

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175295	A. BUILDING _____ B. WING _____	R 01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERET HEALTH AND REHAB AT SMITH CENTER LLC	117 W 1ST ST #369 SMITH CENTER, KS 66967

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12	F 323		

edges on lower part of kick panel. 4) Resident #25's bedroom door kick panel with jagged edges on the lower part. 5) Resident #1's bedroom door kick panel with jagged edges.
6) West Hallway bathroom door kick panel with jagged edges.
7) Resident #5's bedroom door kick panel with jagged and split edges.

South Hallway:
1) Resident #20's bedroom door kick panel with chipped and jagged edges on the lower right side and back of bathroom door kick panel pulling away from door with jagged edges.
2) Resident #36 entrance to bedroom missing threshold between carpet and linoleum.
3) Resident #15 entrance to bedroom missing threshold between carpet and linoleum and bedroom door with approximate 2 inch x 6 inch chunk missing.
4) Resident #4's bedroom door kick panel chipped on both sides with jagged edges.
5) Resident #35's bedroom door kick panel with jagged edges approximately 6 inches on left side.
6) Resident #11's bedroom door with approximately 6 inches of splintered edge.
7) Resident #24's bedroom door kick panel with jagged edges on right side.
8) Resident #6's bedroom door kick panel with approximate 2 inch x 4 inch piece of lower right side missing.
9) Resident #17's bedroom door kick panel with approximate 1 inch x 2 inch chip missing on lower front, and stool riser handles loose.

On 1/6/14 at 10:15 AM, Maintenance Supervisor I verified the housekeeping closet and chemical closet in the whirlpool bathroom should be locked at all times, and the housekeeping cart door lock

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175295	A. BUILDING _____ B. WING _____	R 01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERET HEALTH AND REHAB AT SMITH CENTER LLC	117 W 1ST ST #369 SMITH CENTER, KS 66967

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F 323	Continued From page 13 is broken and doesn't lock. On 1/8/14 at 3:00 PM, Maintenance Supervisory Staff I and J verified the jagged edges of the kick panels and the doors would be a safety hazard. Review of the facility's undated Chemical Storage policy revealed all chemicals are to be stored behind a secured door or cabinet and keys are to be kept out of reach from residents. The facility failed to provide an environment free of accident hazards as possible for 26 residents who reside in the facility.	F 323		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: The facility had a census of 26 residents. The sample included 10 residents. Based on observation, record review and interview, the facility failed to provide a Registered Nurse for 8	F 354		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 354	Continued From page 14	F 354		

consecutive hours a day, 7 days a week, for the 26 residents residing in the facility.

Findings included:

- On 1/6/14 at 9:30 AM, upon entrance to the facility, observation revealed no Director of Nursing in the facility.

The January 2014 licensed and registered nurse staffing schedule revealed the name of the Director of Nursing had been crossed off for the entire month, and no name had been added for the Director of Nursing on the schedule.

Review of the licensed and registered nursing schedule revealed the lack of (RN) Registered Nurse coverage for the following dates:
November 2013: 11/ 8,11/19, and 11/ 25
January 2014: 1/ 4, 1/5, and 1/6.
The schedule further revealed one RN on the staff, who worked the night shift, (7:00 PM-7:00 AM), three shifts per week.

On 1/6/14 at 9:30 AM, observation revealed residents in the dining room drinking coffee, watching television, resting in their rooms, ambulating the halls, or propelling themselves in their wheelchairs in the halls. Further observation revealed a licensed practical nurse, certified medication aide, and 3 certified nurses aides in the facility.

On 1/6/14 at 9:30 AM, Business Office Staff H verified the facility currently does not have a Director of Nursing, and the facility had been without one since 12/31/13.

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F 354	Continued From page 15 On 1/6/14 at 2:00 PM, licensed nurse D verified there is one (RN) Registered Nurse on staff who works three 12 hour shifts a week. On 1/9/14 at 2:30 PM,Consultant Administrative Nurse C, verified no (RN) Registered Nurse coverage for November 8, 10, 25, and January 4, 5, and 6. Consultant Administrative Nurse C verified at this time the facility had no RN coverage on the January 2014 schedule for the dates of the 10th, 13, 15, 18, 19, 24, 27, and the 28th. On 1/9/14 at 2:30 PM, Consultant Administrative Nurse C verified the facility had been without a Director of Nursing since 12/31/13. Consultant Administrative Nurse C also verified a Director of Nursing had been hired, and would begin his/her duties on 2/1/14. The facility failed to provide a registered nurse to act as the Director of Nursing for the 26 residents who reside in the facility, and failed to provide a Registered Nurse for 8 consecutive hours per day, seven days a week, for the 26 residents who reside in the facility.	F 354		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		

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F 441	Continued From page 16 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: The facility had a census of 26 residents. The sample included 10 residents. Based on observation, record review, and interview, the facility failed to follow acceptable standards of infection control regarding the handling of soiled linens and storage of equipment for nebulizer or oxygen use for 1 sampled and 3 unstamped residents. (#11, #36, #27, #4)	F 441		

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F 441	Continued From page 17	F 441		

Findings included:

- On 1/7/14 at 8:19 AM, observation revealed Direct Care Staff K ambulated from Resident #35's room holding soiled linens against his/her uniform.

On 1/7/14 at 8:27 AM and 1/8/14 at 8:00 AM, observation revealed an un-bagged breathing treatment mask hanging on the treatment machine in Resident #11's room.

On 1/8/14 at 7:58 AM, observation revealed an oxygen cannula (the piece that fits into the resident's nose) un-bagged and coiled on top of a portable oxygen tank in Resident #36's room.

On 1/8/14 at 9:45 AM, observation revealed an un-bagged breathing treatment mouth piece laying on top of a breathing machine in Resident #27's room.

On 1/8/14 at 4:28 PM, observation revealed an un-bagged breathing treatment mask hanging on the treatment machine in Resident #11's and #4's rooms.

On 1/8/14 at 4:28 PM, observation revealed an un-bagged breathing treatment mouth piece laying on top of a breathing machine in Resident #27's room.

On 1/9/14 at 8:04 AM, observation revealed an un-bagged breathing treatment mouth piece laying on the floor in front of the breathing machine in Resident #27's room.

On 1/9/14 at 8:05 AM, observation revealed an un-bagged breathing treatment mask hanging on

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F 441	Continued From page 18 the treatment machine in Resident #11's and #4's rooms. On 1/7/14 at 10:13 AM, Administrative Nurse D stated soiled linens should be bagged before removing them from a resident's room and staff should not hold the soiled linens against their uniforms. On 1/9/14 at 8:17 AM, Administrative Nurse D stated all breathing treatment masks, pipes and nasal cannulas should be bagged when not in use. The facility failed to follow acceptable standards of infection control regarding the handling of soiled linens and storage of equipment for nebulizer or oxygen for 1 sampled and 3 unsampled residents. (#11, #36, #27, #4)	F 441		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: The facility had a census of 26 residents. The sample included 10 residents. Based on observation, record review and interview, the facility failed to ensure a working call system which functioned effectively and efficiently for the 26 residents who resided in the facility. Findings included:	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 463	Continued From page 19 - On 1/7/14 at 8:31 AM, observation revealed Resident #15, #28, #25, #6 and #17's call lights audible and signaled outside the room for the resident's room and bathroom but did not signal on the facility's call light system monitoring board. Review of the maintenance logbook revealed the staff randomly checked 1 resident's call system each week. On 1/7/14 at 9:00 AM, Maintenance Supervisor I verified the call lights did not signal on the facility's call light system monitoring board for Resident #15, #28, #25, #6 and #17's room and bathrooms and the facility does not have a policy for checking the call light system. On 1/9/14 at 8:27 AM, Maintenance Supervisor I stated he/she does not check the facility's call light system monitoring board when he/she does the weekly check of 1 resident's call system. The facility failed to ensure a working call system which functioned effectively and efficiently for the 26 residents who resided in the facility.	F 463		
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: The facility had a census of 26 residents. Based on observation and interview, the facility failed to equip corridors with firmly secured handrails on	F 468		

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F 468	Continued From page 20 each side of the hallways in 2 of 3 halls in the facility. Findings included: - On 1/8/14 at 2:17 PM, observation revealed loose handrails between rooms 37 and 38 on the West Hall, outside of room 36 on the West Hall, one wall in hallway to courtyard, and outside of room 23 on the West Hall. On 1/8/14 at 3:00 PM, during the environmental tour, Maintenance Supervisor I verified the hand rails in the West Hall were loose and the handrail on one wall in the hallway to the courtyard was loose. The facility failed to equip corridors with firmly secured handrails on each side of the hallways in 2 of 3 halls in the facility.	F 468		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility had a census of 26 residents. The sample included 10 residents. Based on observation, record review and interview, the facility failed to provide an administrator to attain or maintain the highest practicable physical, mental and psychosocial well-being of each of the	F 490		

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F 490	Continued From page 21 26 residents residing in the facility. Findings included: - On 1/6/14 at 9:30 AM, upon entrance to the facility, observation revealed no administrator in the facility. On 1/6/14 at 9:30 AM, Dietary Staff B stated there was no administrator for the facility. On 1/6/14 at 9:30 AM, Business Office Staff H verified the facility currently does not have an administrator, and had been without anyone in that role since 12/31/13. On 1/6/14 at 10:00 AM, Licensed Nurse D stated because there is no administrator, he/she would notify the facility's business office manager in the event of an emergency at the facility. On 1/6/14 at 10:15 AM, the staff returned the Department Head list given to the facility upon entrance with the word "none" written in the space where the administrator's name would be. On 1/6/14 at 2:10 PM, observation revealed the emergency contact list for the facility, posted at the nurses station, had the name of the administrator crossed off, and no name had been added in it's place. On 1/7/14 at 8:30 AM, Consultant Administrative Nurse C verified the facility had no administrator. Consultant Administrative Nurse C also verified he/she had been at the facility once prior to today since employed as the facility's consultant nurse,	F 490		

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F 490	Continued From page 22 and he/she does not have a Kansas nursing license. On 1/8/14 at 9:00 AM, Consultant Administrative Staff A, verified the facility does not have a current administrator, and had been without one since 12/31/13. The facility failed to employ an administrator to attain or maintain the highest practicable physical,. mental and psychosocial well-being of the 26 residents residing in the facility.	F 490		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	F 520		

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F 520	Continued From page 23 a basis for sanctions. This REQUIREMENT is not met as evidenced by: The facility had a census of 26 residents. The sample included 10 residents. Based on observation, record review and interview, the facility failed to have an effective Quality Assessment and Assurance committee, and the facility's medical director failed to attend meetings at least quarterly for 2013. Findings included: - On 1/9/14 at 11:30 AM, Consultant Administrative Staff A, stated he/she was uncertain as to the Qualtiy Assessment and Assurance process at the facility and what the faciltiy had focused on to improve during the last year. Consultant Administrative Staff A also verified he/she did not know the process of how the staff would contact a committee member to bring a concern to the committee for review. On 1/9/14 at 12:00 PM, Constultant Administrative Staff A verified the faciity held the most recent (QAA) Quality Assessment and Assurance committee meeting on 10/15/13. Consultant Administrative Staff A also verified the facility's medical director had not attended a QAA committee meeting since the last survey, which was 11/26/12 through 12/4/12. On 1/6/14 at 12:00 PM, observation revealed 25 residents in the dining room for the noon meal. The undated facility policy, Quality Assessment	F 520		

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F 520	Continued From page 24 and Assurance Committee stated federal requlations require that a Quality Assessment and Assurance Committee must be held at a minimum, every quarter. This committee is a requirement in order to maintain licensure and meet requirements for participation in the Medicare and Medicaid programs. The policy further states the committee will meet on a monthly basis and include the medical director. The facility failed to ensure the facility had an effective Quality Assessment and Assurance committee which the medical director attended at least quarterly.	F 520		